Legislative Fiscal Bureau
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May 24, 2007 Joint Committee on Finance Paper #395

Family Care Expansion (DHFS -- Long-Term Care)

Bill Section

[LFB 2007-09 Budget Summary: Page 275, #1]

CURRENT LAW

The Family Care program provides community-based long-term care using a managed care model. The program provides comprehensive health care and other supportive services to maintain people in the community under a capitated, risk-based payment system at a limited number of sites throughout the state. A more extensive description of the Family Care program is provided in Attachment 1.

GOVERNOR

Provide $22,406,900 ($2,670,800 GPR, $9,320,900 FED, and $10,415,200 PR) in 2007-08 and $60,808,100 ($17,414,400 GPR, $13,913,600 FED, and $29,480,100 PR) in 2008-09 to reflect the net costs of expanding the Family Care program in the 2007-09 biennium. In addition, make numerous statutory changes to the program.

Attachment 2 provides a complete summary of the Governor's provisions relating to this item.

DISCUSSION POINTS

1. The Family Care program was first authorized under 1999 Act 9, and was initiated as a pilot program in five counties (Fond du Lac, La Crosse, Milwaukee, Portage, and Richland). Recently, the "pilot" status of the program was repealed under 2005 Act 386. This act also

authorized the expansion of Family Care services to areas of the state that encompass up to 50% of the state's population. The approval of the Joint Committee on Finance under a 14-day passive review process is now required before the Department of Health and Family Services (DHFS) can approve any expansion of the Family Care program to areas where, in the aggregate, more than 29% but less than 50% of the population that is eligible for the Family Care benefit reside. In order to expand the program beyond where 50% of the population that is eligible reside, the approval of the full Legislature is required.

2. The bill would repeal current provisions that require the Joint Committee on Finance or the Legislature to approve additional program expansions. Under the bill, DHFS would be authorized to make the Family Care benefit available anywhere in the state, to as many individuals as are eligible for the program.

3. Counties may participate in Family Care either by offering the Family Care benefit or by offering services through aging and disability resource centers (ADRCs). Resource centers provide information, assessments, eligibility determinations and other preliminary services. Care management organizations (CMOs) manage and provide the Family Care benefit for every person enrolled in the program under a capitated, risk-based payment system.

4. The Department and the administration cite several reasons for proposing the program's expansion. In general terms, DHFS staff argue that the expansion of Family Care would provide more service and support options to meet individuals' long-term care needs, improve access to desired community-based services by eliminating waiting lists, improve the quality of long-term care by focusing on and managing for each individual's outcomes, and lay the groundwork for a more cost-effective long-term care system.

5. As part of the program's expansion, DHFS staff anticipate that the establishment of ADRCs statewide would provide a network of information and assistance to senior citizens and individuals with disabilities beyond entry into Family Care, including prevention and wellness education, and referral to other available community resources. Further, staff emphasize that the centers could offer objective, long-term care options counseling that may help individuals expend personal resources more effectively, potentially delaying the need for reliance on publicly-funded assistance. Should assistance be required, the ADRCs would offer benefits counseling to ensure that federally-funded options were fully utilized. Finally, the centers could provide rapid response and referral to crisis care and protective services when needed.

6. Beyond the resource centers, studies suggest that the cost of providing long-term care as part of a managed-care model with case management and care coordination may be lower over time than under a fee-for-service delivery model, and that additional cost savings to primary and acute care costs may be achieved as a benefit of more coordinated, comprehensive care. Further, cost comparisons indicate that, for many individuals, care options within the community currently offered as waiver services may be less expensive than the institutional care options that MA-eligible individuals are entitled to as an MA card-supported service.

As reported in the Department's December 20, 2006, assessment of various institutional relocation and diversion initiatives, the cost to serve most frail elders and individuals with physical or developmental disabilities in the community was, on average, less than the cost to support them in an institutional setting, when both long-term care waiver costs and fee-for-service MA card costs were considered. (An exception to this finding included approximately 300 individuals participating in the ICF-MR relocation program in 2005-06, for whom average MA costs per day increased after relocation as compared to the institutional rates plus the cost of MA card services previously incurred.)

7. For cost savings estimates specific to Family Care, Department staff point to several reports on the program over time, the most recent being an assessment performed by APS Healthcare in September, 2005, to evaluate the accessibility, quality, and cost effectiveness of the program. In terms of cost effectiveness, the assessment found that total MA costs for Family Care participants outside of Milwaukee County were, on average, $452 less per month than comparable counterparts receiving services under MA but not enrolled in the Family Care program. The following table shows the total Medicaid expenditures per member, per month, by service category for calendar years 2003 and 2004, as reported by the APS Healthcare report.

TABLE 1

Medicaid Cost Comparison by Service Category

		Per Member, Per Month Average Cost		
Service Category	Population Served	Family Care Enrollees	Comparison Group	Difference
Non-Milwaukee Family Care	All	$2,656	$3,108	-$452
Non-Milwaukee Family Care	Frail Elderly	2,227	2,501	-274
Milwaukee Family Care	Frail Elderly	2,446	2,501	-55
Non-Milwaukee Family Care	Individuals with Developmental Disabilities	3,534	4,548	-1,014
Non-Milwaukee Family Care	Individuals with Physical Disabilities	2,136	2,404	-268

8. While studies have demonstrated that providing community based long-term care service options like those offered under the Family Care benefit generally reduce the cost per person of providing long-term care services for most individuals (compared to institutional care), total program costs are expected to increase over time in excess of the amount that would otherwise be required to support current programs because with the expansion of Family Care, publicly-funded long-term care services would be provided to more people, including people who are currently on waiting lists to receive home- and community-based waiver services.

Unlike the existing home- and community-based long-term care waiver programs (such as the community integration program (CIP IA, CIP IB, CIP II), the community options program

(COP-W), and the brain injury waiver (BIW)) program, under which enrollment may be controlled by budgeting a set amount of funding per program and then establishing a waiting list for unfunded applicants, the Family Care program is an entitlement for MA recipients who have long-term care needs. As an entitlement, MA recipients who require long-term care must be permitted to enroll in the program and receive services, regardless of cost.

As of April 30, 2007, there were approximately 11,200 individuals on the statewide long-term support waiting list who may potentially qualify for services under the Family Care benefit. Currently, these individuals may be residing in institutions (approximately 6% of the potentially eligible individuals on the waiting list were in nursing homes, state centers, or private ICFs-MR), or they may be living in the community with informal supports, supplemented by MA card services.

Further, DHFS anticipates that individuals not currently on the waiting list and not already participating in MA may be expected to apply for MA and enroll in the Family Care benefit as it becomes available in their area. Past experience in Family Care pilot counties suggest that these previously unserved individuals may increase expected enrollments by less than 2%.

9. In addition to losing the ability to control costs through budgeting and the establishment of waiting lists for services, the establishment of Family Care as an entitlement program removes the ability of the waiver programs to limit care options by capping the amount of funding provided per day to support care plans. Currently, most individuals receiving services through home and community long-term care waivers receive a specified dollar amount per day to support the cost of their approved package of services, and may access MA card services to meet other care needs. This amount is capped under the waiver programs, requiring participants to manage their costs within the available funding level, or requiring counties to supplement state funds with county contributions.

Under the Family Care benefit, enrollees are entitled to a full package of home and community based services, in order to meet their care needs as assessed by a CMO (as opposed to being restricted by a dollar amount per person, per day). The impact of this shift may be moderated by the CMO's ability to assist individuals with care planning and case management, assuring that while all necessary services are provided, few non-essential services are provided to the enrollee.

10. Under the anticipated expansions assumed under the budget, it is expected that the percentage of the state population served by ADRCs will increase from the current 40% to approximately 75% by June, 2009. The portion of the state population served by Family Care CMOs is expected to increase from the current 17% to as many as 62% during that same time period. Under the Department's implementation planning, it is anticipated that ADRCs will begin operating in geographical areas at least two months prior to the services of a regional CMO becoming available, in order to educate eligible individuals about the Family Care benefit and to begin enrolling members.

While the speed of the member enrollment process may vary depending on the size and the prior operating experience of the CMOs, the organization's contract requires that the enrollment of

specified populations of eligible individuals are completed within the first two years of operation. Generally, CMOs are directed to enroll current participants in the current home and community-based waiver programs first, followed by individuals on waiting lists for home and community based services, individuals supported by MA in the community who may have unmet long-term care needs, individuals who are not currently enrolled in MA (and who would not have enrolled except to take advantage of the Family Care benefit), and MA-eligible individuals receiving institutional care who chose to relocate into the community. The Department's cost estimates assume that the enrollment process for each expansion will require the full two-year phase in to be complete.

11. In 2005-06, DHFS paid CMOs capitation payments totaling approximately $233.8 million (all funds). DHFS provides funding to support aging and disability resource centers (ADRCs) on a calendar year basis. In calendar year 2006, DHFS estimated that state support for aging and disability resource centers totaled approximately $9.7 million.

12. The expansion of the Family Care program would be funded with: (a) additional state and federal MA funding that would be provided under this budget item; (b) reallocations of base funds that support MA fee-for-service payments and MA waiver services; (c) funding available in 2006-07 that would be used to support costs in the 2007-09 biennium; and (d) county funds, including community aids and revenue from the county tax levy. The bill assumes that counties will contribute an amount equal to the funds that counties expended in calendar year 2005 to provide services to long-term support clients. A program revenue appropriation would be created for DHFS to collect these funds from counties. Attachment 4 summarizes the funding components of this item.

13. As shown in Attachment 4, cost increases associated with the expansion (excluding offsetting one-time savings and possible county contributions) would total $21,750,000 (all funds) in 2007-08 and $37,090,700 (all funds) in 2008-09. Of the amount required, $5.8 million in 2007-08 and $13.9 million would support costs related to increased CMO enrollment. The remaining $16.0 million in 2007-08 and $23.2 million would be directed to support the expansion and operation of ADRCs and to support costs associated with the external quality review of the program. Of the amount provided to support ADRC costs, $9.6 million (60%) in 2007-08 and $9.9 million (over 40%) in 2008-09 would be directed to fully fund ADRCs that were opened during the 2005-07 biennium without sufficient ongoing base funding from the Department.

14. Funding for ADRCs is budgeted based on the estimated size of the population to be served in each area. Studies documenting the amount of time required to respond to inquiries for various groups of consumers were performed in the Family Care pilot counties, and those results were generalized to develop a funding model. Because ADRCs provide services to, and respond to, inquiries from individuals and their families pre-enrollment and regardless of MA eligibility, federal cost sharing for their operation is limited to the amount that can be documented as supporting services for MA-eligible individuals. Currently, the federal reimbursement rate for ADRC costs that can be documented and claimed is approximately 24%.

15. The Department's model suggests that the expansion of ADRCs to fully cover all 72

counties may be complete as early as 2010-11. Based on statewide population estimates, DHFS projections anticipate the annual cost to continue for ADRCs to increase by $45.9 million ($35.0 million GPR and $10.9 million FED) above 2006-07 base funding levels when all ADRCs are open and operational in 2010-11. However, the Department has indicated that these estimates are based primarily on the projected costs related only to the number of individuals to be served in each region, and that actual costs may be higher as ADRC services are extended into rural areas with more widely dispersed populations. Department staff indicates that DHFS intends to fully fund ADRC costs required to provide the specified package of services.

16. The CMO component of Family Care is expected to increase steadily over time as well. While the administration has announced a goal of implementing the Family Care program statewide within five years, DHFS estimates indicate that the program is unlikely to reach a fully mature, stabilized enrollment throughout the state until as late as 2015, at which point costs would be begin to be primarily driven by provider rate fluctuations (as opposed to increases in enrollment related to program expansion). The cost model for the expansion of Family Care CMOs incorporates assumptions regarding the anticipated starting dates of service for various regions, target groups of expected enrollees for each region, cost adjustments based on the health and service use histories by population group, information on expected costs based on the utilization patterns of current waiver enrollees and known waitlist populations, estimates of new enrollees based on prior counties' experience with Family Care, program and administrative costs trends adjusted for the difference in expected CMO performance from start-up through stabilization, and other factors based on the costs and operating experiences pilot Family Care counties, the current statewide waiver programs, and the state's eligible MA population in general.

17. The following table summarizes the growth in enrollment, costs, and offsetting funding reductions (such as reallocation of base funds that support MA fee-for-service payments and MA waiver services, and anticipated county contributions) predicted by year under the expansion model through the next biennium. Given the potential for variability in anticipated start dates of various regional consortia and the potential effect of those changes on estimated outcomes, projections beyond the current budgeting biennia (2007-09) should not be considered precise.

TABLE 2

Estimated CMO Expansion

	New Enrollments	GPR	FED	County Contribution
2007-08	7,766	$700,700	$951,100	$9,563,600
2008-09	16,612	5,031,800	6,994,500	38,228,800
2009-10	29,257	10,327,000	14,355,200	83,900,300
2010-11	35,328	22,885,400	31,812,000	95,032,300

18. A major component of the administration's plan for funding the Family Care

expansion includes the assumption that counties would contribute the equivalent of what DHFS calculates the county spent in calendar year 2005 to provide services to the population of individuals who would otherwise have been eligible for the Family Care benefit, had it been available at that time. Attachment 5 details the amount of the expected contribution, by county, assumed by DHFS and the administration in developing the cost estimate. At full statewide implementation, this would require an annual contribution of $95.7 million from the counties. Under the bill, this contribution may either be transferred from the county to the Department and deposited to a program revenue appropriation created under the bill, or a county could authorize DHFS to withhold the amount from the county's community aids basic county allocation (BCA).

19. While the Department and the administration included anticipated revenues of $10.4 million in 2007-08 and $29.5 million in 2008-09 from county contributions in its proposal to support anticipated Family Care expansion costs, DHFS staff acknowledge that no agreement has yet been reached with any of the counties considering potential Family Care expansion plans in the 2007-09 biennium with respect to the amount of funding each county would contribute.

20. As shown in Attachment 5, the estimated county contribution ranges from no funding for Menomonee County to a high of $20.2 million annually for Dane County. Counties have raised objections to the administration's assumptions about the size and distribution of the estimated contributions. Some counties have disagreed with the Department's estimates, indicating that they believed the calculations inaccurately represented the amount of county levy directed toward applicable expenditures for that year. Others have raised equity arguments, comparing the size of the newly-estimated buy-in cost to the amount that pilot counties were expected to contribute when the Family Care program began in 1999 (equivalent to 22% of each of the pilot counties BCA, an amount determined through DHFS surveys to represent an average amount spent by counties on long-term care at that time). Still others have objected to the requirement of a substantial maintenance-of-effort payment funded by the county levy without any guarantee that the current high levels of service that these funds support will be maintained under a managed-care environment.

21. In a September 28, 2006, letter, to DHFS, the Wisconsin Counties Association, proposed an alternative funding arrangement, under which counties participating in the Family Care program would initially contribute the annual amount specified by DHFS in its fiscal estimate, but that required contributions would decrease over a five-year phase in period to an amount equal to 22% of the individual county's BCA. If the amount of the Department's estimated 2005 contribution was lower than 22% of the county's BCA, the county would simply pay the estimated contribution with no further adjustment. In total, this proposal would decrease county contributions by $52.6 million annually from the amount assumed by DHFS to a total of $43.1 million annually (at full statewide implementation). The effect of this proposal, by county, is included in Attachment 5. Alternatively, the Association suggested the Department consider using the lesser of each county's 2003, 2004, or 2005 contribution towards long-term care costs. At this time, there is no known agreement between the Department and the Wisconsin Counties Association on the resolution of this issue. Further, it is not clear (based on the variety of concerns raised by different counties) whether any such agreement would be accepted by all counties.

22. Under the bill, the Governor proposes deleting current statutory provisions that require DHFS to obtain the permission of local long-term care counsels and counties before contracting with a CMO to provide the Family Care benefit in a county. This change was proposed in conjunction with the proposed elimination of references to long-term care councils in statute, as a result of the creation of Family Care councils. However, a resulting effect would be the removal of the current law requirement that DHFS seek the approval and participation of counties prior to expanding the Family Care program. Under current law, Family Care program expansions are voluntary, and require the consent (if not the cooperation) of the county. Further, DHFS has indicated that it is the Department's intent to continue to contract only with willing partners. Without the current provision however, it would be possible for DHFS to contract with a CMO to provide the Family Care benefit for a county or group of counties without their consent or participation, should the Department desire to expand the program and the county or counties refuse to participate. While this possibility seems remote in the near future, questions may be raised about how aggressively the administration intends to pursue its long-term plan for complete state coverage, when numerous counties have expressed concerns or hesitancy about participating.

23. While the bill assumes that counties would contribute the amounts identified in Attachment 5 as a condition of their participation in the Family Care expansion, there is no provision in the bill requiring financial participation on the part of the counties, or providing DHFS with means to recoup costs from counties should local governments chose to alter future financial participation agreements after CMOs have been established, and community waiver participants enrolled in the program. In the event that a county would chose to withhold funds, the Department would seem to have three options: (a) cancel the regional provider contracts supporting the delivery of the Family Care benefit (to the significant disruption of enrollees and provider networks); (b) withhold the disputed amount from community aids payments that the state would have otherwise provided to the county (an option the Department questions its authority to do, based on current statutory requirements to provide support for the populations served by these funds); or (c) seek additional state funding in lieu of the county contribution.

If the Committee is concerned about the potential cost shifting from county contributions to GPR in future years, the Committee could provide DHFS with the authority to withhold an amount of community aids funding from counties equal to the amount that the county owed the state as a result of a prior agreement to support the county's contribution for receiving Family Care services.

24. As previously noted, under the bill there would be no requirement that DHFS secure the consent or participation of a county before contracting with a CMO to provide the Family Care benefit, and there is no requirement that DHFS seek or secure appropriate financial participation agreement from the counties before expanding the program. While the bill assumes local financial support, there is no requirement for DHFS to secure it as a term of the Family Care expansion contract if the county objects. Further, any financial concessions made by the Department in agreements to one county may set precedents insisted upon by other counties. Given the difficulties that the Department has experienced negotiating a financial participation agreement with a variety of counties, and the publicly stated reluctance of the Wisconsin Counties Association to proceed without a broad-based, equitable funding agreement that addresses the concerns of its membership,

it may be in the interest of the Committee to require DHFS to establish a formal policy on the treatment of local financial participation agreements before the state commits to expanding Family Care. This could be accomplished by deleting the Governor's recommendation to remove the Committee's oversight under passive review process for new expansions. The Committee could then require the Department to demonstrate that it established (and was enforcing) a consistent policy on local financial participation before any additional ADRC or CMO expansion were authorized.

25. Alternatively, if the Committee determines that state and federal funding were primarily the most appropriate form of support for the expansion of the Family Care program, the Committee could allow the Department to proceed using its discretion to determine an appropriate amount of local financial support for counties to contribute.

26. Subsequent to the release of the Governor's budget, the Department revised several budgetary assumptions based on updated data. As a result, a portion of the funding originally provided under the bill for the operation of CMOs would decrease by $2,535,800 GPR; funding provided for the operation of ADRCs would increase by $2,326,300 GPR; and $200,000 GPR would be directed on a one-time basis to support IT systems modifications to support ADRCs. As the federal match for expenditures related to ADRCs is lower, a decrease in federal matching funds of $2,602,000 is anticipated as well. The net result of these changes would be a decrease in the amount provided under the bill of $9,500 GPR and $2,602,000 FED. Staff in the administration indicate that the changes requested by the Department reflect the intent of the Governor to appropriately fund the expansion initiative. Consequently, Alternative 1 in this paper reflects the adjusted appropriations requested by the Department and supported by the administration.

27. The Department requested (and the administration concurred) that a statutory change included in the bill that would replace the current titles of definitions of functional eligibility for the Family Care benefit with "nursing home level of care," rather than "comprehensive," and "non-nursing home level of care," rather than "intermediate" should be made effective January 1, 2008, rather than being made effective with the date of the bill for the sake of administrative simplicity.

28. Finally, the Committee has the option of deleting this item from the budget. While this would have the effect of ceasing any additional expansion of the Family Care program during the 2007-09 biennium (and potentially beyond, if the Committee's action served to dissuade potential participants from continuing to plan to participate), removing funding provided under the bill would also affect several ADRCs that DHFS contracted with during the 2005-07 biennium. As previously noted, a portion of the funding provided under this item ($9.6 million in 2007-08 and $9.9 million in 2008-09) would be directed to fully fund ADRCs that were opened during the 2005-07 biennium without sufficient ongoing base funding from the Department. If these funds were removed, county funding may be required to support their operation, or they may be required to close. Alternatively, the Committee could provide adequate base funding to support the operations of existing ADRCS, but decline to fund further expansion.

ALTERNATIVES TO BILL

A. Funding

1. Approve the Governor's recommended funding provisions (as reestimated) to expand the Family Care program.

ALTA 1	Change to Bill Funding	Change to Base Funding
GPR	- $9,500	$20,075,700
FED	- 2,602,000	20,632,500
SEG	0	39,895,300
Total	- $2,611,500	$80,603,500

2. Delete the provisions of the bill relating to the expansion of the Family Care benefit. However, provide $9,609,500 ($7,339,800 GPR and $2,269,700 FED) in 2007-08 and $9,855,500 ($7,527,700 GPR and $2,327,800 FED) in 2008-09 to fully fund the operation of existing ADRCs.

ALT A2	Change to Bill Funding	Change to Base Funding
GPR	- $5,217,700	$14,867,500
FED	- 18,637,000	4,597,500
SEG	- 39,895,300	0
Total	- $63,750,000	$19,465,000

3. Delete provision.

ALT A2	Change to Bill Funding	Change to Base Funding
GPR	- $20,085,200	$0
FED	- 23,234,500	0
SEG	- 39,895,300	0
Total	- $83,215,000	$0

B. Statutory Changes

1. Adopt all of the Governor's recommended statutory changes to the program.

2. Modify the statutory changes in the bill by adopting one or more of the following.

a. Make statutory changes to the bill that were requested by the administration, as described in Discussion Point 22. This change would specify that the provisions in the bill that

would replace the current titles of definitions of functional eligibility for the Family Care benefit with "nursing home level of care," rather than "comprehensive," and "non-nursing home level of care," rather than "intermediate" be made effective January 1, 2008, rather than on the effective with the date of the bill.

b. Maintain current law provisions that would require DHFS, prior to expanding the availability of Family Care to areas of the state where more than 29% but less than 50% of the population eligible for the benefit reside, to apply for the approval of the Joint Committee on Finance under a 14-day passive review process and provide the Committee with certain information regarding the proposed expansion (including a copy of the proposed contract and information demonstrating that the expansion is cost-neutral). Further, maintain the current law requirement that in order to expand Family Care contracted services to areas of the state where, in aggregate, more than 50% of the population that is eligible for the benefit reside, the approval of the full Legislature is required. Maintain the current law requirement that DHFS obtain approval from the Joint Committee on Finance before expanding the use of capitated rate payment programs to provide long-term care services. Maintain the current law provision that prohibits DHFS from entering into contracts for resource centers without the approval of the Joint Committee on Finance.

c. Maintain the current law requirement that DHFS obtain legislative approval to enter into a contract to establish a CMO with an entity other than a county, Family Care district, Indian tribe or band, or the Great Lakes Inter-Tribal Council, Inc. Maintain current law requirements that DHFS consult with local long-term care councils or with the county before selecting applicants with which to contract for CMO services. Maintain the current law provision that prohibits DHFS from contracting for a CMO to serve an area unless the local long-term care council for the area has developed an initial plan to implement Family Care.

d. Require DHFS to develop, implement, and enforce a consistent and equitable policy for establishing an appropriate level of local financial participation as a pre-requisite for expanding Family Care services to additional counties. Require the Department to include information on this policy, and evidence of consent to the policy by participating counties in any future request to the Joint Committee on Finance under the 14-day passive review process for expansion of the Family Care program.

e. Authorize DHFS to withhold community aids funding from counties who have entered into agreements with the Department to provide financial support for Family Care program services, and who subsequently violate this agreement. Specify that the Department may only withhold the amount owed to the state by the county under the agreement, and the withheld funds be directed to support costs associated with the Family Care program.

Prepared by: Rebecca Hotynski
Attachments

ATTACHMENT 1

Family Care Program – Background

The Family Care program is a comprehensive long-term care program that was created to provide cost-effective, comprehensive and flexible long-term care services to Wisconsin residents. Since its creation in 1998, the program has been offered in counties that have elected to participate in the program. Consequently, the Family Care program is not currently available in all areas of the state.

In counties that do not participate in the program, medical assistance (MA) recipients may receive medically necessary MA-funded long-term care "card" services, including care provided by nursing homes, home health care, and personal care services. MA recipients are entitled to receive these card services, subject to certain limitations, if they require these services.

In addition, some MA recipients in the non-Family Care counties that would qualify for institutional care may participate in the MA home- and community-based waiver programs, such as the community integration program (CIP IA, CIP IB, CIP II), and the community options waiver program (COP-W). These programs fund certain long-term care services that are not available to all MA recipients as card services. Examples of these "MA waiver services" are services provided by community-based residential facilities, adult family homes and residential care apartment complexes (above the level of room and board), adult day care, and respite care services. However, unlike MA card services, MA recipients are not entitled to receive MA waiver services. Consequently, in many counties, there are waiting lists for these services. In addition, unlike MA card services, for which providers submit claims for reimbursement to the MA program, MA waiver services are funded from sum certain allocations to counties. Counties also provide their own funds, including community aids and tax levy revenue, to support these long-term care services. The state claims federal MA matching funds for MA-eligible services counties support with these funds.

Family Care Benefit. In seven counties, individuals may enroll in CMOs, which are responsible for assuring that enrollees receive long-term care services. Funding for acute care services, such as hospital and physician services, are not part of the monthly capitation rate CMOs receive. These costs are billed to MA on a fee-for-services basis. CMOs develop and manage a comprehensive network of long-term care services and supports, either through contracts with providers, or by providing care directly through the CMOs' employees. In this way, CMOs, like health maintenance organizations, have an incentive to provide cost-effective care to enrollees.

The state's MA program makes capitation payments to CMOs, which are funded from a combination of GPR and federal MA matching funds. In 2007, these capitation payments range from $2,093 per month for elderly enrollees requiring a comprehensive level of care in

Milwaukee County, to $2,670 per month for enrollees in all three target groups requiring a comprehensive level of care in Kenosha and Racine Counties. For individuals who require an intermediate level of care, CMOs in each county receive a capitation payment equal to $691 per month.

Individuals who enroll in CMOs to receive the Family Care benefit have access to a broad range of services, including the MA waiver services and some MA card services that are provided through the CMO. Attachment 3 to this paper lists MA waiver services available to individuals receiving the Family Care benefit. Card services that may be provided through the CMO include (but are not limited to) care provided by nursing homes, home health services, personal care services, medical supplies, physical therapy, and transportation services. Family Care enrollees receive other services, such as physician services, on a fee-for-service basis.

MA recipients who require long-term care services in Family Care counties may elect to participate in Family Care (and therefore be eligible for the Family Care benefit), or not. However, in Family Care counties, individuals who choose not to enroll in Family Care do not have access to the MA waiver services that are available in non-Family Care counties, since Family Care replaces the home- and community-based waiver programs in those counties. Instead, they may continue to receive MA card services on a fee-for-service basis

As of March 31, CMOs operated in seven counties (Fond du Lac, Kenosha, La Crosse, Milwaukee, Portage, Racine and Richland Counties). Each of these counties, except Milwaukee County, served the three target population groups -- elderly individuals, individuals with developmental disabilities, and individuals with physical disabilities. The Milwaukee County CMO currently serves elderly clients, exclusively.

The following table identifies total CMO enrollment, by county and target group, as of March 31, 2007.

Total CMO Enrollment by Target Group
March 31, 2007

County	Elderly Individuals	Individuals with Developmental Disabilities	Individuals with Physical Disabilities	Total
Fond du Lac	456	369	156	981
Kenosha	53	62	40	155
La Crosse	660	553	559	1,772
Milwaukee	6,161	0	0	6,161
Portage	453	264	207	924
Racine	147	72	20	239
Richland	176	108	77	361
Total	8,106	1,428	1,059	10,593

Aging and Disability Resource Centers. (ADRCs) serve as a single entry point for individuals who may require long-term care services. ADRCs provide information and advice about the range of resources available to them in their communities, and serve as a clearinghouse for information on long-term care, accessible to health care providers, hospital discharge planners, and other professionals who work with elderly individuals and individuals with disabilities. Services provided by ADRCs include information and assistance, long-term care options counseling, benefits counseling, emergency response (for example, following the sudden loss of a caregiver), prevention and early intervention services. In addition, ADRCs administer the long-term care functional screen to assess individuals' level of need for services and eligibility for the Family Care benefit.

ADRCs currently serve provide services to residents in 22 counties, including the seven counties served by CMOs and the following 15 additional counties: Jackson, Marathon, Trempealeau, Barron, Brown, Calumet, Outagamie, Waupaca, Green, Sheboygan, Manitowoc, Green Lake, Waushara, Marquette and Forest Counties.

ATTACHMENT 2

Summary of Family Care Provisions Included in SB 40

Funding Under the Bill

The bill would provide $22,406,900 ($2,670,800 GPR, $9,320,900 FED, and $10,415,200 PR) in 2007-08 and $60,808,100 ($17,414,400 GPR, $13,913,600 FED, and $29,480,100 PR) in 2008-09 to reflect the Administration's estimates of the net costs of expanding the Family Care program in the 2007-09 biennium.

Summary of Expansion

Aging and Disability Resource Centers (ADRCs). ADRCs, which provide information, counseling, and assessment services, serve as the primary point of entry for accessing long-term care services. There are currently 18 ADRCs operating in Wisconsin. The bill would fund additional ADRCs so that the percentage of Wisconsin residents who have access to these services would increase from approximately 40% to 75% by the end of the biennium.

Care Management Organizations (CMOs). Currently, five CMOs receive monthly capitation payments from the state to fund long-term care services to Family Care enrollees. The bill would fund additional CMOs so that by the end of the biennium, approximately 27,200 individuals would be enrolled in Family Care, compared to 10,300 as of February 1, 2007. It is not known which counties or multi-county regions would be served by CMOs, nor is it known when additional CMOs would begin operating. The administration's proposal is based on a model that makes a number of assumptions regarding these and other factors that affect program costs.

External Quality Review. DHFS contracts with a vendor to conduct external quality review functions. The bill would increase funding for these contracted services.

Offsetting Funding Reductions, Reallocations, and County Contributions. This item would be funded with: (a) additional state and federal MA funding that would be provided under this recommendation; (b) reallocations of base funds that support MA fee-for-service payments and MA waiver services; (c) funding available in 2006-07 that would be used to support costs in the 2007-09 biennium; and (d) county funds, including community aids and revenue from the county tax levy. The bill assumes that counties will contribute an amount equal to the funds that counties expended in calendar year 2005 to provide services to long-term support clients. A program revenue appropriation would be created for DHFS to collect these funds from counties.

In 2005-06, DHFS paid CMOs capitation payments totaling approximately $233.8 million (all funds). DHFS provides funding to support aging and disability resource centers

(ADRCs) on a calendar year basis. In calendar year 2006, DHFS estimated that state support for aging and disability resource centers totaled approximately $9.7 million.

Statutory Changes

Authority to Expand Program. Repeal the provision that requires DHFS, prior to expanding the availability of Family Care to areas of the state where more than 29% but less than 50% of the population eligible for the benefit reside, to apply for the approval of the Joint Committee on Finance under a 14-day passive review process and provide the Committee with certain information regarding the proposed expansion (including a copy of the proposed contract and information demonstrating that the expansion is cost-neutral). Under current law, DHFS may make the Family Care benefit available in areas of the state in which, in the aggregate, not more than 29% of the population that is eligible for the benefit resides. DHFS may contract with additional CMOs in areas where, in the aggregate, more than 29% but less than 50% of the population that is eligible for the benefit resides, provided that the Joint Committee on Finance approves each expansion (up to the 50% cap) under a 14-day passive review process.

Under current law, in order to expand Family Care contracted services to areas of the state where, in aggregate, more than 50% of the population that is eligible for the benefit reside, the approval of the full Legislature. Under the bill, DHFS would be authorized to make the Family Care benefit available anywhere in the state, without prior approval from the Legislature or the administration.

Eliminate the current law requirement that DHFS obtain approval from the Joint Committee on Finance before expanding the use of capitated rate payment programs to provide long-term care services.

Contracts. Eliminate the current provision that requires DHFS to obtain legislative approval to enter into a contract to establish a CMO with an entity other than a county, Family Care district, Indian tribe or band, or the Great Lakes Inter-Tribal Council, Inc.

Clarify current statutory provisions allowing DHFS to contract with counties, Family Care districts, the governing body of a tribe or band or the Great Lakes Inter-Tribal Council, Inc., or under a joint application of any of these, or with a private organization that has no significant connection to an entity that operates a resource center. Require that proposals for contracts be solicited under a competitive sealed proposal process. Direct DHFS to evaluate the proposals primarily as to the quality of care that is proposed to be provided, and to certify those applicants that meet the necessary requirements. Repeal the requirement that DHFS consult with local long-term care councils or with the county before selecting applicants with which to contract. Repeal the provision that prohibits DHFS from contracting for a CMO to serve an area unless the local long-term care council for the area has developed an initial plan to implement Family Care.

Repeal the provision that prohibits DHFS from entering into contracts for resource centers without the approval of the Joint Committee on Finance. Under the bill, DHFS would no longer require legislative consent to enter into contracts for resource centers.

Eligibility and Entitlement. Repeal provisions that identify one of the qualifying conditions for being eligible for the Family Care benefit as suffering from a "degenerative brain disorder." Instead, provide that an individual may be eligible for the Family Care benefit if they are a "frail elder." Define a frail elder as someone who is 65 years of age or older and who has a physical disability or irreversible dementia that restricts the individual's ability to perform normal daily tasks, or that threatens their capacity to live independently.

Replace the current titles of definitions of functional eligibility for the Family Care benefit with "nursing home level of care," rather than "comprehensive," and "non-nursing home level of care," rather than "intermediate." The definitions clarifying when an individual has met each level of functional eligibility would remain unchanged.

Eliminate the requirement that DHFS extend entitlement for the Family Care benefit to people who are not eligible for MA by January 1, 2008. Allow individuals who are not eligible for MA, but who are currently receiving services under the Family Care benefit upon the passage of the bill to continue to be eligible for, but not entitled to, the Family Care benefit. Require that an individual be eligible for MA in order to be entitled to the Family Care benefit.

Under current law, DHFS must extend entitlement to the Family Care benefit by January 1, 2008, to individuals who are not MA eligible but who are functionally eligible at the comprehensive level or who are in need of protective services or protective placement and are functionally eligible at the intermediate level, as well as to certain individuals who are not MA eligible but who are functionally eligible because they were receiving other long-term care benefits (such as community waiver services)when the Family Care program was implemented in their county.

Long-Term Care Councils. Define which family members of individuals who meet certain Family Care eligibility requirements are eligible to serve on local long-term care councils to include spouses, or individuals related by blood, marriage, or adoption within the third degree of kinship.

Notification Requirements. Repeal the requirement that a resource center notify residents of certain long-term care residential facilities who are potentially eligible for the Family Care benefit of the services that the center provides within six months after the benefit is made available in the area. Resource centers would still be required to provide notification of services to these individuals; however, under the bill, there would be no time requirement for doing so.

CMO Contracts for Home Health Services. Clarify that if a CMO contracts with an entity to provide home health services under Family Care, the entity need not be licensed as a

home health agency for the purpose of providing the contracted services. Under current law, CMOs do not need to be licensed as home health agencies.

Functional and Financial Screens. Clarify that the functional screen and the financial screen performed by resource centers are separate screens. Require that an assessment of a person's ability to pay for part of the Family Care benefit be conducted as part of the financial screen conducted by the resource center.

Use of Community Aids and COP Funds and County Contributions. Specify that, for counties with CMOs, DHFS may allocate a portion of that county's basic community aids allocation to fund the operation of the county's resource center and CMO. Limit the amount of the allocation to an amount agreed to by both DHFS and the county. Currently, DHFS may allocate up to 21.3% of a county's community aids allocation for this purpose.

Create an appropriation for financial contributions by counties to support Family Care, the program for all-inclusive care for the elderly (PACE), and the Wisconsin Partnership Program (WPP) for program operation, services, or to contribute to a risk reserve.

Permit any county in which Family Care, WPP, or PACE is available to use its community options (COP) allocation to provide mental health or substance abuse services, or to provide services under the family support program. Currently, state law requires counties to allocate COP funds to serve a minimum percentage of clients in four eligible groups: elderly, developmentally disabled, physically disabled, and chronically mentally ill. Counties offering Family Care, WPP, or PACE benefits would not be subject to this requirement.

Information and Referral Requirements. Repeal the requirement that adult family homes provide information to prospective residents regarding resource centers and the Family Care Benefit, and refer prospective residents to the resource centers. Further, repeal the requirement that hospitals refer certain patients to resource centers prior to discharging them.

Instead, in counties where the services of a resource center are available, require community-based residential facilities (CBRFs) and residential care apartment complexes (RCACs) to provide information regarding resource centers and the Family Care benefit to prospective residents, and if a referral is required, refer prospective residents to resource centers when the facilities first provide prospective residents with written materials regarding their facilities. Permit DHFS to specify by rule the method by which the CBRFs and RCACs make referrals to the resource centers, as well as acceptable time period allowed for nursing homes to provide information to prospective residents about resource centers and the Family Care benefit, and to make referrals to the resource center.

In counties that do not have resource centers, require CBRFs (but not RCACs) to refer certain prospective residents that are aged or who have a physical or developmental disability to the county department responsible for administering long-term care programs. Require the

county, within the time period specified by DHFS, to offer the prospective resident counseling concerning public and private long-term care benefit programs.

Repeal the requirement that CBRFs assess the financial condition of privately paying clients prior to admission. Further, delete the current law restriction prohibiting counties from using certain community long-term care waiver funds to pay for care in a CBRF for a program recipient who did not undergo an assessment of their abilities, disabilities, service needs, and a review of alternatives to institutional care before entering a CBRF.

Create Long-Term Care Districts Rename Family Care districts "long-term care districts," and authorize these districts to operate the WPP or PACE programs, as long as the district does not also operate a resource center. Clarify that a county, a tribe or band, or any combination of counties or tribes or bands may create a long-term care district. Specify that a county or tribe or band may create more than one long-term care district, and that a district may change its primary purpose (from operating either a CMO or a resource center to operating the other) if all of the counties or tribes or bands that created the district have not withdrawn or been removed from the district adopt a resolution approving the change, and if the change does not violate any provision of a contract between DHFS and the district, and as long as the change does not result in the same district simultaneously operating a CMO and a resource center.

Provide that a long-term care district may establish conditions for a county or tribe or band that participated with one or more counties or tribes or bands in creating a district to withdraw from the district, or for the district to remove the county or tribe or band from the district, subject to the approval of DHFS.

Specify that the jurisdiction of a long-term care district includes the geographical area of the county or counties that created it, as well as the geographic area of the reservation of, or lands held in trust for, any tribe or band that created the long-term care district.

Require that when a county, tribe, or band opts to create a long-term care district board, they must also specify the number of individuals who will be appointed as members of the long-term care district board, the length of their terms, and if the district is created by more than one county or tribe or band, how many members shall be appointed by each.

Clarify that any member of a long-term care district governing board may be removed by the appointing authority for cause. Delete current requirements specifying the total number of board members who must be appointed, their length of term, and the requirement that one-fourth of the board's membership consist of older persons or persons with physical or developmental disabilities or their family members, guardians, or other advocates who are representative of the CMO's enrollees. Instead, require that at least one-fourth of the board's membership be representative of the client group or groups whom the CMO is contracted to serve, or those clients' family members, guardians, or other advocates. Provide that only individuals who reside within the jurisdiction of the long-term care district may serve as members of the board.

Provide that the board may act based on the affirmative vote of a majority of a quorum, unless specified otherwise in a bylaw adopted by the board.

Clarify that the provisions regulating the compensation that the district must offer an individual who formerly worked for a county participating in the district in a substantially similar function, and whose wages, hours and conditions of employment were established in a collective bargaining agreement with the county, must apply specifically to the employee's wages, vacation allowance, sick leave accumulation, sick leave bank, holiday allowance, funeral leave allowance, personal day allowance, and paid time off allowance, rather than the previously provided "compensation and benefits."

Delete the requirement that the district initially provide the same compensation and benefits to individuals who formerly worked for a county participating in the district in a substantially similar function, but whose wages, hours and conditions of employment were not established in a collective bargaining agreement.

Delete the current provision providing that subject to the terms of any applicable collective bargaining agreement, long-term care district employees are eligible to receive health care coverage under any county health insurance plan that is offered to county employees. Instead, provide that if the district employs any individual who was previously employed by the county, the district is directed to provide health care coverage that is similar to the health care coverage that the county provided the individual with while employed by the county.

Delete the current requirement that long-term care district employees remain eligible to participate in any deferred compensation or other benefit plan offered by the county to county employees, including disability and long-term care insurance coverage and income continuation insurance coverage. Specify that the long-term care district and the county may enter into an agreement allocating the costs of providing employee benefits between the district and the county.

Current law specifies that the obligations and debts of a long-term care district are not those of any county. Further clarify that if a long-term care district is obligated by statute or contract to provide or pay for services or benefits, no county is responsible for providing or paying for those costs.

Resource Center Governing Boards, Local and Regional Committees. Provide that if the governing board of a resource center (rather than the local long-term care council, as provided under current law) assumes the duties of the county long-term support planning committee, that planning committee is dissolved. Similarly, if the governing board of the resource center assumes these duties, the board must also recommend a community options plan for participation in the program and monitor its implementation. Eliminate local long-term care committees.

Delete current provisions requiring that one-fourth of the membership of any resource center's governing board be older persons, or individuals with a physical or developmental disability, individuals who belong to a client group served by the resource center, or their family members, guardians, or other advocates. Instead, provide that at least one-fourth of the membership of the governing board must consist of individuals who belong to a client group served by the resource center or their family members, guardians, or other advocates. Specify that the proportion of these board members who belong to each client group, or their family members, guardians, or advocates be the same as the proportion of individuals in the state who receive services under the Family Care benefit and belong to each client group.

Prohibit any individual who has a financial interest in, or serves on the governing board of a CMO, PACE, or WPP program, an SSI managed care plan, or who has a family member with any of these same conflicts, from serving on the governing board of a resource center.

Direct that the governing board of a resource center be responsible for:

(1) determining the structure, policies, and procedures of the resource center and overseeing its operations, and specify that the operations of a resource center that is operated by a county is subject to a county's ordinances and budget;

(2) annually gathering information from consumers and providers of long-term care services and others concerning the adequacy of services offered in the area;

(3) identifying any gaps in services, living arrangements, and community resources needed by individuals belonging to client groups served by the resource center, especially those with long-term care needs;

(4) providing well-advertised opportunities for persons to participate in the board's information gathering activities;

(5) reporting findings to the regional long-term care advisory committee;

(6) recommending strategies for building local capacity to serve older persons and individuals with physical and developmental disabilities to local elected officials, the regional long term care advisory committee, and to DHFS;

(7) annually reviewing interagency agreements between the resource center and CMOs that provide services in the area, and make recommendations on the interaction between the two to assure coordination between them, and to assure access to and timeliness of the provision of services;

(8) reviewing the number and type of grievances and appeals concerning the long term care system in the area served by the resource center, to determine if a need exists for system changes, and recommend changes as appropriate;

(9) identifying potential new sources of community resources and funding for needed services for individuals belonging to the client groups served by the resource center;

(10) if directed to do so by the county board, assuming the duties of the county long-term community support planning committee; and

(11) appointing members to the regional long term care advisory committee.

Direct the governing board of each resource center operating in a given region established by DHFS to appoint members to a regional long-term care advisory committee. Specify that at least 50% of the appointees must be older persons, individuals with a physical or developmental disability, or their family members, guardians, or other advocates. In establishing each region, the Department is directed to periodically review the boundaries of the regions, and revise them as appropriate. Further, direct DHFS to specify the number of members that each governing board of a resource center must appoint to the regional advisory committee. Specify that the total number of committee members may not exceed 25. Require DHFS to allot committee membership equally among the governing boards of resource centers operating within the boundaries of the regional long-term care advisory committee. Further, direct DHFS to provide information and staff assistance to aid the regional committees in performing their duties.

Define the duties of the regional long-term care advisory committees to include all of the following: (1) to evaluate the performance of CMOs, PACE, and WPP programs in the region with respect to their responsiveness towards recipients of their services, fostering choices for recipients, and other issues affecting recipients, and to make recommendations based on these evaluations to DHFS and the evaluated entities; (2) to evaluate the performance of the resource centers operating in the region and make recommendations concerning their performance to DHFS and the centers; (3) to monitor grievances and appeals made to CMOS, PACE, and WPP programs within the region; (4) to review the utilization of long-term care services in the region; (5) to monitor enrollments and disenrollments in CMOs that provide services in the committee's region; (6) using information gathered by the governing boards of resource centers operating in the region and other available information, to identify any gaps in the availability of services, living arrangements, and community resources needed by older persons and individuals with physical or developmental disabilities, and to develop strategies to build capacity to address those gaps; (7) to perform long-range planning on long-term care policy for individuals belonging to the client groups served by the resource center; and (8) to annually report to DHFS regarding significant achievements and problems relating to the provision of long-term care services in the committee's region.

Require resource centers to target any outreach, education, and prevention services that it provides and any service development efforts that it conducts on the basis of findings made by the governing board of the resource center.

ATTACHMENT 3

Covered Items and Services Under the Family Care Benefit

- Adaptive Aids (general and vehicle)
- Adult Day Care
- Alcohol and Other Drug Abuse Day Treatment Services (in all settings)
- Alcohol and Other Drug Abuse Services, except those provided by a physician or on an inpatient basis
- Care/Case Management (including Assessment and Case Planning)
- Communication Aids/Interpreter Services
- Community Support Program
- Consumer Education and Training
- Counseling and Therapeutic Resources
- Daily Living Skills Training
- Day Services/Treatment
- Durable Medical Equipment, except for hearing aids and prosthetics (in all settings)
- Home Health
- Home Modifications
- Housing Counseling
- Meals: home delivered
- Medical Supplies
- Mental Health Day Treatment Services (in all settings)
- Mental Health Services, except those provided by a physician or on an inpatient basis
- Nursing Facility (all stays including Intermediate Care Facility for People with Mental Retardation (ICF/MR) and Institution for Mental Disease
- Nursing Services (including respiratory care, intermittent and private duty nursing) and Nursing Services
- Occupational Therapy (in all settings except for inpatient hospital)
- Personal Care
- Personal Emergency Response System Services

- Physical Therapy (in all settings except for inpatient hospital)
- Prevocational Services
- Relocation Services
- Residential Services: Certified Residential Care Apartment Complex (RCAC), Community-Based Residential Facility (CBRF), Adult Family Home
- Respite Care (for care givers and members in non-institutional and institutional settings)
- Specialized Medical Supplies
- Speech and Language Pathology Services (in all settings except for inpatient hospital)
- Supported Employment
- Supportive Home Care
- Transportation: Select Medicaid covered (i.e., Medicaid covered Transportation Services except Ambulance and transportation by common carrier) and non-Medicaid covered

ATTACHMENT 4

Family Care Expansion
Governor's Recommendations

Cost Category	2007-08 GPR*	2007-08 FED	2007-08 PR	2007-08 Total	2008-09 GPR*	2008-09 FED	2008-09 PR	2008-09 Total
Funding For Services to New Family Care Enrollees								
New Costs								
CMO Capitation Payments	$42,953,300	$72,441,400	$10,415,200	$125,809,900	$109,675,600	$193,434,200	$29,480,100	$332,589,900
MA Services Provided on a Fee-For-Service Basis	13,342,100	18,110,400	0	31,452,500	34,788,900	48,358,500	0	83,147,400
Reductions from Other Programs								
MA Fee-for-Service Payments	-32,021,900	-43,465,800	0	-75,487,700	-87,056,800	-121,013,900	0	-208,070,700
Allocations to Counties for Waiver Services	-21,813,900	-43,747,000	0	-65,560,900	-51,599,300	-112,704,900	0	-164,304,200
Net Funding for Services to New Family Care Enrollees	$2,459,600	$3,339,000	$10,415,200	$16,213,800	$5,808,300	$8,073,900	$29,480,100	$43,362,300
Aging and Disability Resource Centers (ADRCs)								
New Costs								
Fund ADRCs that Began in 2005-07 Biennium	$7,339,800	$2,269,700	$0	$9,609,500	$7,527,700	$2,327,800	$0	$9,855,500
Fund ADRCs that Begin in 2007-09 Biennium	2,562,100	3,240,300	0	5,802,400	9,765,600	3,086,000	0	12,851,600
Available Funds to Support ADRCs								
Income Augmentation Funds from 2006 Plan	-1,257,800	0	0	-1,257,800	0	0	0	0
Reallocations of Base Funds and One-Time Carryover Funds	-8,500,500	0	0	-8,500,500	-5,762,800	0	0	-5,762,800
Net Funding to Support ADRCs	$43,600	$5,510,000	$0	$5,553,600	$11,530,500	$5,413,800	$0	$16,944,300
External Quality Review	$167,600	$471,900	$0	$639,500	$75,500	$425,900	$0	$501,400
GRAND TOTAL	**$2,670,800**	**$9,320,900**	**$10,415,200**	**$22,406,900**	**$17,414,400**	**$13,913,600**	**$29,480,100**	**$60,808,100**

*Includes both one-time and ongoing funds that DHFS would reallocate to support ADRCs.

ATTACHMENT 5

County Contributions for Family Care Expansion

County	Waiver Enrollees Served	Waiting List	Total 2005 County Expenditures for Waiver & Wait List	DHFS Proposed County Contribution	County Association Proposed County Contribution
Adams	132	92	$4,731,900	$41,400	$41,400
Ashland	127	141	6,026,300	377,300	243,400
Barron	247	160	10,494,400	639,100	456,500
Bayfield	140	48	6,039,600	774,900	179,300
Brown	1,156	568	46,165,200	4,828,400	2,075,000
Buffalo	100	33	3,277,000	145,300	145,300
Burnett	98	39	2,698,800	86,900	86,900
Calumet	169		5,815,000	1,175,900	272,200
Chippewa	283	38	9,270,900	622,300	611,000
Clark	202	34	8,491,100	995,600	420,800
Columbia	265	282	12,821,700	1,899,900	424,000
Crawford	140	12	4,854,000	282,000	282,000
Dane	1,825	563	106,530,100	20,231,800	3,893,100
Dodge	243	124	11,062,500	1,141,000	682,200
Door	137	24	4,142,700	469,700	250,600
Douglas	376	134	14,606,100	958,000	651,200
Dunn	149	22	7,592,800	804,000	396,400
Eau Claire	332	62	17,237,600	1,598,700	1,139,800
Florence	37		489,400	1,200	1,200
Forest	86	13	2,564,000	103,600	68,800
Grant	225	110	9,741,900	366,500	236,700
Green	231	85	5,990,600	229,000	229,000
Green Lake	79	43	4,038,300	629,300	180,600
Iowa	78	23	2,949,700	97,700	97,700
Iron	45	33	1,357,900	53,200	53,200
Jackson	158	14	5,622,200	597,000	307,800
Jefferson	494	156	20,396,400	2,043,200	625,100
Juneau	105	95	3,895,200	900	900
Kenosha	609	670	29,247,400	2,114,300	1,749,300
Kewaunee	189	1	5,354,100	332,000	194,000
Lafayette	83	27	2,729,600	305,000	192,800
Langlade	184	2	4,556,600	442,900	91,300
Lincoln	225	19	6,222,500	829,800	185,600
Manitowoc	403	257	15,108,000	996,800	869,000
Marathon	666	322	27,066,800	3,653,900	409,300
Marinette	242	150	8,893,300	298,100	298,100
Marquette	87	46	2,728,900	200,500	145,000
Menominee	45		1,219,900	0	0
Milwaukee	2,368	1,635	126,148,400	7,217,200	7,217,200
Monroe	223	94	7,290,100	678,900	415,000

County	Waiver Enrollees Served	Waiting List	Total 2005 County Expenditures for Waiver & Wait List	DHFS Proposed County Contribution	County Asso. Proposed County Contribution
Oconto	135	133	$9,146,100	$1,574,900	$299,700
Oneida	260	33	7,654,400	386,500	126,900
Outagamie	456	328	21,010,800	2,499,400	1,401,300
Ozaukee	267	84	11,532,100	2,126,100	575,600
Pepin	78	25	2,690,000	185,200	136,100
Pierce	169	22	6,938,600	439,900	307,800
Polk	165	88	6,196,400	474,700	416,500
Price	131	47	4,118,200	306,700	187,500
Racine	638	187	24,239,300	851,100	851,100
Rock	866	272	34,580,800	3,670,300	2,026,700
Rusk	152	152	5,792,300	409,100	241,500
Sauk	356	199	12,410,200	1,377,500	510,800
Sawyer	106	98	4,137,700	166,500	166,500
Shawano	282	52	7,337,500	656,000	360,900
Sheboygan	627	73	19,641,500	2,443,700	1,104,400
St. Croix	230	138	14,626,600	2,564,400	376,000
Taylor	165	16	3,880,000	173,700	173,700
Trempealeau	265	66	6,908,700	483,400	345,300
Vernon	129	66	5,033,800	552,000	322,300
Vilas	158	136	5,058,300	153,000	65,500
Walworth	420	140	14,606,100	1,370,400	749,600
Washburn	158	86	5,462,100	637,500	198,300
Washington	460	104	17,511,100	2,718,500	767,400
Waukesha	953	519	40,856,300	3,883,800	2,504,600
Waupaca	299	204	9,649,100	1,046,300	435,500
Waushara	153	60	4,363,800	349,500	236,000
Winnebago	718	396	33,589,200	5,121,800	1,594,600
Wood	357	244	12,115,900	815,900	807,800
Total	22,136	10,139	$926,555,600	$95,700,900	$43,108,300